PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

EnvisionRx On-Line Prior Authorization Form

Phone: 866-250-2005 Fax back to: 877-503-7231

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name: ☐ Expedited/Urgent

Directions:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. Please provide the patient's diagnosis below:
Q2. Have other formulary alternatives in this drug category/class been tried and failed? ☐ Yes ☐ No
Q3. Please list them below along with the date the medication was tried and failed.
Q4. If the patient is unable to tolerate the formulary alternative, what is the issue the patient is having? ☐ The patient has an allergy to the formulary alternative ☐ Other
Q5. If Other, please describe below:
Q6. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support a request for off-label use. Please attach any medical information that may support approval.
Q7. Please provide any supporting clinical statements (such as chart notes, lab values, or any other additional clinicalinformation) to support an authorization request.

Physician Signature **Date**